Transforming Cultures of Care Toward Recovery Oriented Services:
Guidelines toward Creating a Trauma Informed System of Care

Trauma Informed Care (TIC) Planning Guidelines for use in Developing an Organizational Action Plan ©
National Association of State Mental Health Program Directors, Inc.

Purpose: For use as a template or checklist that guides the design of a trauma informed system of care that incorporates the use of a prevention approach, operationalizes the core principles of trauma informed care, and ascribes to the philosophy of continuous quality improvement. Also may be used as a monitoring tool to evaluate or direct the implementation of trauma-informed principles in a way that will assist to identify problems, issues, barriers and successes. Best used as a working guide by an assigned Performance Improvement or Trauma Informed Care Team or Task Force. Trauma informed care, in this context, is believed to be a cornerstone toward creating care environments that facilitate the rehabilitation or recovery process of persons (adults and children) who have serious mental illnesses or co-occurring disorders.

Note: The word *consumer* is used sometimes in this document, which refers to adults, children and families. There is also some overlap between goals and objectives as activities in some areas that can be inserted in more than one goal area; this choice is left up to the facility to make.

Trauma Informed Planning Guidelines or Monitoring Tool Draft Instrument
(Each item needs to be documented (e.g., observation, evidenced in, leadership activities, staff interviews, review of policies, etc.)

STRATEGY ONE: EFFECTIVE LEADERSHIP IN ORGANIZATIONAL CHANGE

GOAL ONE: Leadership will prioritize the reduction of discrimination and stigma, the use of historically coercive practices such as seclusion and restraint, environmentally-based iatrogenic conflict and violence, and the lack of sincere inclusion of consumers by defining and articulating a philosophy of care, guiding values, and assuring for the development and implementation of a system of care that is trauma informed. The guidance, direction, participation and ongoing review by executive leadership is clearly demonstrated throughout this project.

1. **Review/Revise Facility Mission/Vision Statement, Philosophy and Core Values**

   Has the facility leadership reviewed/revised the facility mission statement, philosophy and core values to assure congruence with trauma informed care principles? For example, creating violence free and coercion free environments based on prevention strategies; assuring a safe environment for staff and children; referencing Seclusion and Restraint (S/R) reduction as congruent with principles of recovery; building a trauma informed system of care. This step must include an organizational values exercise

where values statements are cross-walked with actual clinical and administrative practices to assure for congruence.

2. **Develop a Facility-wide Trauma Informed Policy Statement**

Has organizational leadership developed a facility-wide trauma informed policy statement that includes beliefs to guide use? Is the policy statement congruent with the mission, vision, values and recovery principles? This policy would include procedures such as universal trauma assessments and the creation of safety plans, assessment and risk management of the potential for violence, restriction of the use of S/R as not treatment but a safety measure of last resort and the facility's commitment to reduction/elimination or S/R and other restrictive, isolating practices etc. There are examples of policy statements available to review.

3. **Develop an individualized, facility-based Trauma Informed Implementation Plan**

Has leadership developed a individualized, facility-based Trauma Informed Implementation Plan based on a performance improvement and prevention approach as the overall umbrella including the assignment of a TIC or PI team; the creation of goals, objectives and action steps assigned to responsible individuals and noted due dates; and are there consistent reviews and revisions with senior executive oversight and review? (See policy statement, policy and procedures, actual plan.)

4. **Leadership Involvement in Data Assessment**

Has leadership reviewed and analyzed their conflictual or violent incidents (self or other), the use of involuntary medications and/or S/R related data in an effort to discover critical details of events such as time of day, location, points of conflicts? Has leadership determined data driven hospital goals to reduce conflict and violence? (See data component for specifics.) This objective basically is leaderships' commitment and intention to use and monitor real time data in monitoring the implementation of culture change.

5. **Active and Ongoing Focus on Creating Collaborative and Non-punitive Work Environments**

Is leadership committed to creating a collaborative, non-punitive environment, to identify and work through problems by communicating expectations to staff, and to be consistent in maintenance of effort? This step would include the ability of leadership, with staff help, to identify environmental triggers that lead to conflict. This step may include a statement to staff that while individual staff members may act with best intent, it may be determined later that there were other avenues or interventions that could have been taken. It is only through staff's trust in leadership that they will be able to speak freely of the circumstances leading up to a conflictual or violent event so that

this event can be carefully analyzed and learning occur. However, the rules defining abuse and neglect are clear and the previous statement does not lift accountability for those kinds of performance issues.

6. CEO/Administrator Plays Active and Visible Role in TIC Initiative

Are all staff aware of the role of the CEO/Administrator to direct the TIC initiative? This will include senior level involvement in motivating staff including and understanding and commitment from the facility medical director. A "kickoff" event for the rollout of this initiative is recommended or a celebration if facility is already involved in this effort. This step calls for active, routine and observable CEO/Administrator activities including the inclusion of status report at all management meetings.

7. Evaluate and Plan for Impact of TIC Initiative on Service Environment

Has leadership evaluated the impact of implementing trauma informed care principles the service environment? This includes issues such as increased destruction of property; extended time involved in de-escalation attempts, additional admission assessment questions, debriefing activities and processes to document event, etc.

8. Plan for Ongoing Staff Recognition

Has the leadership set up a staff recognition project to reward individual staff, unit staff and TIC champions for their work on an ongoing basis? This can be done formally or informally, on units or in meetings and can consist of anything from a certificate for file to a coupon for a free lunch.

9. Delegation and Accountability

Does the leadership delegate tasks and hold people accountable through routine reports and reviews? Is someone identified on the senior leadership level that reviews the TIC plan and the implementation and routinely provides feedback?

10. Active, Person-centered and Choice Define Clinical Treatment Activities

Has leadership reviewed the facility's plan for clinical treatment activities in an effort to assure that active, daily, person-centered, effective treatment activities are offered to all persons receiving services; that these services are offered off living units preferably; and that persons attending have some personal choice in what activities they attend? The minimal criteria to meet under this objective is to assure that service recipients are not spending their days in enclosed areas with no active psycho-social or psychiatric rehabilitation occurring that are effective in teaching living, learning, recreational, and working skills.

11. Oversight Accountability/Witnessing Role Developed

Has facility leadership ensured oversight accountability by watching and elevating the visibility of every self abusive event, aggressive event, use of S/R, use of involuntary medication event or other events of concern, 24 hours/7 days per week by assigning specific duties and responsibilities to multiple levels of staff including on-call executives, on-site nursing supervisor, direct care staff, advocates or consumers? This is done to identify antecedents to incidents that may be institutional in nature (including staff practices) and can be changed. In addition, this kind of oversight will assist in identifying individual consumer triggers and in revising safety plans.

Note: Creating responsibilities for the oversight of the use of physical management interventions including seclusion/restraint; the use of involuntary medications; events that are near misses and any other events of concern to the organization includes the following functions:

a. On-call Executive Role (member of executive team)

1) 24/7 on call supervision for event analysis
2) Respond to unit calls in one hour of event
3) Use knowledge gained by event analysis to identify organizational problems, potential resolutions and ensure timely follow-up
4) Ensure that data is collected, used and shared
5) Ensure staff accountability and performance recognition

b. On-site Supervisor Role

1) 24-hour onsite response to any identified event that includes supervision and attendance at all events and near misses when possible (to observe what worked and why)
2) Takes lead, post event, by debriefing all staff involved, the child involved, all event witnesses, gathers event timelines, reviews documentation, and provides a report (verbally and written) to oncoming supervisor or administrator

c. Line Staff (Direct Care)

1) Understand and be able to describe the organizational approach in implementing TIC and reducing untoward events
2) Be introduced to project and philosophy, through:

- New hire application and interview
- New staff orientation
- Job description

- Competency review
- Meet performance criteria in evaluations
- Demonstrate positive attitude about the project

d. Consumer Role

1) Use employed internal consumer staff or external consumer consultants to act as interviewers, gather data, investigate and to provide a critical perspective of event, post event
2) Be represented on all TIC or S/R related committees and task forces
3) Be used as key informants

STRATEGY TWO: USING DATA TO MONITOR CHANGE

GOAL TWO: To increase the use of trauma informed activities by using data to assess implementation efforts. Includes conducting random record reviews to assess whether critical trauma informed components are evident in children's records and other facility documentation. To reduce the emergence of conflict or violence by using data in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage of S/R, involuntary medications, self injury, aggression, time outs, use and responses to level program consequences, elopement by unit, shift day, and staff member or other variables the organization wants to measure. Also includes identifying facility baselines; setting improvement goals and comparatively monitoring measures chosen by use over time in all care areas, units and/or state system's like facilities.

1. Increasing Trauma Informed Activities

Are random record reviews conducted at least quarterly to assess whether a variety of trauma informed care elements have been implemented? The record reviews should assess, but not be limited to, the following:

    a. Whether person first language is always used in the records?
    b. Whether a focus on consumer strengths is emphasized throughout the record?
    c. Whether persons served are given fully voice and choice related to all treatment activities?
    d. Whether persons served are provided individualized and comprehensive support in order to fully participate in all treatment reviews and meetings (for children, the same for family members)?
    e. Whether every person served has received a comprehensive trauma assessment?
    f. Whether results of the trauma assessments are fully integrated into the treatment plans and safety/crisis plans?

    g. Whether individual safety/crisis plans are developed for each individual?

    h. Whether the individual safety/crisis plans are fully integrated into everyday unit activities and integrated into community activities?

    i. Whether individual sensory assessments have been conducted and results incorporated into safety/crisis plans and everyday unit activities?

    j. Whether sensitivity and support and full inclusion in problem solving follow each incident consumer is involved in?

    k. Whether trauma specific treatment activities are provided for persons with documented histories of trauma and/or arrangements for such treatment is made when transferred to the community?

2. Identifying Baseline, Core and Adjunctive Variables to Monitor

Has the facility collected and graphed baseline data on identified variables to include at a minimum, incidents, hours, and injuries? Has the facility chosen standard core and supplemental measures including seclusion and restraint incidents and hours by shift, day, unit, time; use of involuntary IM medications; consumer and staff related injury rates; use of time outs; consumer involvement in event debriefing activities; grievances, consumer demographics including gender, race; diagnosis, insurance type; incidence of elopements; incidence of grievances; and other measures as desired?

3. Setting Performance Goals

Has the facility set goals and communicated these to staff, setting realistic data improvement thresholds? Has the facility created non-punitive, healthy competition among units or sister facilities by posting data in general treatment areas and through letters of agreement with external facilities?

4. Monitoring Individual Staff Involvement

Does leadership have access to data that represents individual staff member involvement in conflictual or violence related events and is this information kept confidential and used to identify training needs for individual staff members? (For supervisors only.)

5. Recording "Near Misses"

Is the facility able to observe and record "near misses" for restrictive procedures such as S/R and involuntary medication (and the processes involved in those successful events) to assist in leadership and staff learning of best practices to reduce these?

STRATEGY THREE: WORKFORCE DEVELOPMENT

GOAL THREE: To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. This includes an understanding of the characteristics and principles of trauma informed care systems. Also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff training and education and HRD activities. Includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. Also includes the provision of effective and person centered psychosocial or psychiatric rehabilitation like treatment activities on a daily basis that are designed to teach life skills (See Goal One).

1. Human Resource Activities and Hiring Process

   a. Has the facility included HR in the planning and implementation efforts to include the development and insertion of knowledge, skills and abilities considered mandatory in job descriptions and competencies for all staff at every level of the organization? Does this include both technical competence and attitudinal competence and how these are demonstrated?

   b. Do advertisements and interview protocols reflect facility values related to TIC? For instance, do interviewers assess for sensitivity, relationship building skills, beliefs about support versus consequences?

2. **Orientation/Training Process**

   a. Has the staff development department introduced recovery/resiliency, prevention, and performance improvement theory and rationales to staff?

   b. Has the facility assured for education/training for staff at all levels in theory and approaches including:

      1) Experiences of consumers and staff in mental health settings?
      2) What is Trauma?
      3) Common assumptions and myths about treatment and practices such as the use of consequence based level systems and treatment planning?
      4) Courtesy in providing care (priority)

5) Neurobiological Effects of Trauma?
6) Public Health Prevention Model?
7) Performance Improvement Principles?
8) Reducing S/R (Core Strategies) as appropriate?
9) Assessing Risks for Violence?
10) Medical/Physical Risk Factor for Injury or Death in take downs/restraint use?
11) The use of Safety Planning Tools or Advance Directives to direct practice in situations of escalation or conflicts?
12) Core Skills in Building Therapeutic and Person Based Relationships?
13) Safe Restraint application procedures including continuous face-to-face monitoring while a person is in restraint?
14) Non-confrontational limit setting?

3. **Strength-based Supervision Process**

   a. Does the organization have in place a strength-based supervision process that is competency based and includes formal planned and spontaneous observations of skills related to TIC?

   b. Does the organization provide senior clinical oversight in daily operations that are trained to identify consumers or staff who may require additional, non-standard trauma services? (This would include access to trauma specific services, trauma experts and, for staff, competent, confidential and accessible EAP services)

4. **Focus on Staff Empowerment**

   a. Has the facility encouraged staff to explore unit "rules" with an eye to analyzing these for logic and necessity? (Most inpatient and residential facilities have historical rules that are habits or patterns of behavior that are not congruent with a non-coercive, recovery facilitating environment, for instance rules such as putting people who self-abuse in non lethal ways in restraint, or putting people who are intrusive only in restraint, seclusion or time out. Also includes the indiscriminate use of involuntary or prn medications that are not defined well or reviewed routinely.)

   b. Has the facility addressed staff empowerment issues? (For example do staff have input into rules and regulations?) Does the facility allow staff to suspend "rules" within defined limits to avoid conflicts or let the consumer "win"?

    c. Does the facility empower staff in general? (e.g. self-schedule, flex schedules, and monitoring of staff morale through staff satisfaction surveys with follow-up)

    d. Does the facility involve staff in the culture improvement process and provide all levels of staff with regular opportunities for discussion, asking questions and sharing concerns?

    e. Does the facility assume that all staff at all levels are responsible, capable adults, albeit perhaps injured by trauma, and communicated this value to all? How?

5. **Administrative Oversight**

    a. Has the facility revised the organizational mission, philosophy, and policies and procedures to address the above theory and principles?

    b. Has the facility appointed a committee and chair to address workforce development agenda and lead this organizational change? (Include HR)

STRATEGY FOUR: IDENTIFYING AND MANAGING RISK FACTORS ASSOCIATED WITH CONFLICT AND VIOLENCE

GOAL FOUR: To prevent or mitigate the development of conflict or violence through the use of trauma informed risk management strategies that are integrated into organizational operations and policies. Includes the use of universal assessment questions to identify risk factors for self or other directed violence and the use of assessments to identify persons with risk factors for death and injury in S/R.

1. **Managing risks for aggression and violence**

Has the facility implemented assessment tools to identify risk factors for incidents of aggression and violence? Research shows that one predictor is past violent behavior in inpatient/residential settings and past involvement with S/R use. Other predictors may be documented histories of trauma or witnessing violence, experiences in the foster care system, homelessness, certain diagnosis, and learned responses to perceived external threat. (Examples of tools are available.)

2. **Implementing risk assessment tools for preventing deaths or serious injuries in physical management techniques**

Has the facility implemented assessment tools on the most common risk factors for death or serious injury caused by physical management of violence or restraint use? These include obesity, history of respiratory problems including asthma,

recent ingestion of food, certain medications, polypharmacy, history of cardiac problems, and history of acute stress disorder or PTSD.

STRATEGY FIVE: IMPLEMENTING TRAUMA SENSITIVE TREATMENT SERVICES

GOAL FIVE: To implement the use of integrated trauma sensitive treatment services that include the use of a universal trauma assessment; the use of de-escalation or safety assessment tool; the development of crisis or safety plans; the implementation of environmental changes to include comfort and sensory rooms; the provision of trauma education and activities that promote/teach trauma informed self care and emotional management skills; the availability of consultation for trauma specific services for those persons with persistent symptoms of Acute Stress Disorder (ASD) or PTSD; and other meaningful clinical interventions that assist people in learning emotional self management.

1. **ASSESSMENTS AND INDIVIDUALIZED TREATMENT/SUPPORTS**

    a. Has the facility implemented the use of a universal trauma history assessment that identifies persons at risk for re-traumatization and addresses signs and symptoms related to untreated trauma sequelae? (Examples of tools are available)

    b. Has the facility implemented universal de-escalation tools or safety planning assessments that includes the identification of individual triggers and personally chosen and effective emotional self management interventions? (Examples of tools are available.)

    c. Has the facility created a way that individual safety planning or de-escalation information is readily available in a crisis, is used, reviewed as necessary and is integrated in the treatment plan?

    d. Has the facility implemented trauma education groups for identified trauma survivors and do these include self care information and individualized emotional self management skill acquisition?

2. **MOVING FROM CONTROL TO COLLABORATION AND SUPPORT**

    a. Has the facility:

        1) Implemented communication techniques/conflict mediation procedures and practices?
        2) Reduced environmental signs of overt/covert coercion such as large key rings on staff, excessive use of rules, consequenced based policies,

negative signage, minimal staff supervision on high stress units, shaming or demeaning language?

3) Made environment of care changes (use of comfort rooms & sensory rooms)?

b. Has the facility utilized a behavioral scale that assists staff to discriminate between agitated, disruptive, destructive, dangerous and lethal behaviors and decreases the premature use of restraint/seclusion? (This step would include staff training in matching interventions to levels of behavioral escalation to avoid the premature use of physical management)

c. Has the facility written policies and procedures for use of the above interventions and disseminated these to all staff?

3. EXPERT CONSULTATION:

a. Has the facility made available expert and timely consultation with appropriately trained staff or consultants to assist in developing individualized, trauma specific behavioral interventions for service recipients who demonstrate consistently challenging behaviors or severe sequalae from trauma such as ASD or PTSD?

STRATEGY SIX: CHILD/FAMILY AND ADVOCACY ROLES IN CARE SETTINGS

GOAL SIX: To assure for the full and formal inclusion of children (when possible, families and advocates in a variety of roles in the organization to assist in the implementation of trauma informed care principles.

1. Valuing Choice

Has the facility integrated consumer choices at every opportunity? For children's treatment programs this also assumes a focus on family member choices and or external advocate roles?

2. Meaningful Roles

Has the facility used vacant FTE's to create full or part-time roles for older adolescent/adult consumers/family members of children/adolescents (if relevant) such as:

1) Director of Advocacy Services?
2) Director of Family Support Services
3) Peer Specialists?
4) Drop-In Center Director?

     5) Community Consumers?
     6) Training Partners?

   a. Has the facility educated staff as to the importance and need to involve family members and/or advocates at all operational levels, both through respectful inclusion in operations decisions as appropriate and in the consistent attention to the provision of choices?

   b. Has the facility included consumer, family and/or advocacy representation in key committees and workgroups throughout organization?

   c. Has the facility empowered families and advocates to do their facility related jobs and support this work (new roles for families or advocates) at the highest level by setting up appropriate supervision and support systems?

2. FEEDBACK:

   a. Has the facility implemented customer satisfaction surveys, discussed results with staff and used results to direct revisions in service provision? In children's programs satisfaction surveys would also be geared to families.

   b. Has the facility invited external advocates to provide suggestions and be involved in operations?

STRATEGY SEVEN: DEBRIEFING TECHNIQUES

GOAL SEVEN: To assist in the implementation of a system of care that is trauma informed by reducing incidents characterized by conflict, violence, or aggression through knowledge gained from a rigorous analysis of these kinds of events when they occur (including S/R events) and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a S/R and//or the use of involuntary stat medication events for involved staff and consumers and all witnesses to the event. (It is imperative that senior clinical and medical staff, including the medical director, participate in these events.)

   1. Explicating Debriefing Policy and Procedures

   a. Has the facility revised policy and procedures to include two debriefing activities for each conflictual/aggressive incident, S/R event or involuntary medication event as follows:

     1) An immediate "post-event" debriefing that is done onsite after each event, is led by the senior on-site supervisor who immediately responds to that

unit or area? The goals of this post-acute event debriefing is to assure that everyone is safe, that documentation is sufficient to be helpful in later analysis, to briefly check in with involved staff, consumers and witnesses to the event to gather information, to try and return the milieu to pre-event status, to identify potential needs for policy and procedure revisions, and to assure that if the consumer is restrained he/she are safe and being monitored appropriately. If the facility has implemented "witnessing" (see Goal One) the on-site supervisor calls in the information gathered in this post-acute debriefing event to the off site executive staff person who is on call or report to administration if during weekday hours.

2) A formal debriefing that includes a rigorous analysis that occurs one to several days following the event and includes attendance by the involved staff, the treatment team including the attending physician, and a representative administration. It is recommended that this formal debriefing follow the steps in a root cause analysis [RCA] or a similar rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid in the future. It is also recommended that RCA be used in situations where individuals are injured; where S/R has been used more than twice in a month; at any time where S/R event lasts more than eight hours and whenever involuntary medication is used.

3) Has the facility assured the involvement of the consumer in all debriefing activities either in person or by proxy? It is extremely important to include the consumers experience or voice in this activity and if the consumer cannot or will not participate it is recommended that another consumer or staff person act as that person's advocate at the meeting. It is also recommended that the consumer, in staff, or advocacy roles, also be involved and that the person running the meeting is well versed in objective problem solving and was not involved in the triggering event.

b. Do the debriefing and involuntary medication policies and procedures specify: (see Debriefing P & P)

1) Goals of debriefing?
2) Who is present?
3) Responsibilities/roles?
4) Process?
5) Documentation?
6) Follow-up?

c. Has the facility implemented debriefing policies and procedure that address staff responses to the event, consumer responses and issues, and "observer" response and issues?

d. Has the facility provided training on how debriefing will revise treatment planning?

e. Has the facility made an attempt to assist staff in their individual responses to conflict or violence in their work environment, up to and including the use of EAP (Employee Assistance Program) services or other supportive resources?